

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12503

## CERTIFICATE OF DEATH

Reg. Dist. No. 3230

1. PLACE OF DEATH *Baltimore*  
 County .....  
 City or town .....  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....  
 Hospital, Institution, or street address where death occurred: *P.D. #2*

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infant, give residence of mother)

State ..... *Md.* County .....  
 City or town .....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *P.D. #2*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

*Bertha Arrey*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Walter Thomas Arrey*

7. Birth date of deceased (mo., day, yr.) *No Record - 1900 -* 6. (c) If alive, give age *46* years

8. AGE: Years *46* Months — Days — If less than one day — hrs. — min.

9. Birthplace *Sussex Co. Delaware* (Town, county, and state)

10. Usual occupation *House wife*

11. Industry or business *at Home*

12. Name *George Brattin*

13. Birthplace *Sussex Co. Del.*

14. Maiden name *Maria Parsons*

15. Birthplace *P.O. Parsonburg Md.*

16. Informant *Mr. Walter J. Arrey*

Address *P.O. #2 Parsonburg Md.*

17. Burial, cremation, or removal. Which? *Burial* Date thereof *Dec. 4-46* (month) (day) (year)

Cemetery or crematory *Bethel Cem.*

Location *Walston Maryland*

18. Funeral director *Hessney & Co. Walter R. Holloway*

Address *Saltby Maryland*

19. (At fee by registrar) *12/4/46* 19 *W.C. Gray* *J. Johnson* Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH *Dec. 1st 1946*

2D. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Nov. 29 46* to *Dec. 1 1946*, to and that I last saw her alive on *Nov. 29 1946*.

Immediate cause of death

*CA of Pancreas*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

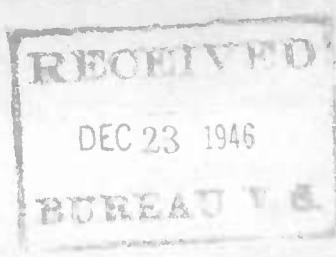
Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE

*Julian D. Gray* M.D. or other

Address ..... Date signed *12/3/46*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 116

12504

## CERTIFICATE OF DEATH

Reg. Dist. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County *Wicomico*City or town *Salisbury and*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Don't know*

Hospital, Institution, or street address where death occurred:

*Pennsylvania General Hospital*How long in hospital or institution? *About 3 hours*

## 3. (a) FULL NAME

*Fred Lee Bell*4. Sex *Male* 5. Color or race *C.* 6. (a) Single, married, widowed, or divorced *married*6. (b) Name of husband or wife *Leahbourne Bell* *Don't know*6. (c) If alive, give age *Don't know* years7. Birth date of deceased (mo., day, yr.) *May 30 1890*8. AGE: Years *about 56* Months *7* Days *24* If less than one dayhrs. *0* min. *0*9. Birthplace *Waycross Georgia* (Town, county, and state)10. Usual occupation *Salvage*11. Industry or business *Same as above*12. Name *Unknown*13. Birthplace *Unknown*14. Maiden name *Unknown*15. Birthplace *Unknown*16. Informant *Welfare Office Wicomico*Address *Salisbury and*17. Burial *Public* Date thereof *Mar 16, 1946*

(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory *Public*Location *Salisbury and*18. Funeral director *James P. Stewart*Address *Salisbury and*19. *125/16, 1946* Date received by registrar *Frank E. Johnson*

(Date received by registrar) (Signature of Registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *Wicomico*City or town *Salisbury and* (If outside city or town limits, write RURAL and give nearest town)Street No. *Salisbury and* (If rural, give LOCATION)2. (a) If veteran, name war *Don't know*

## 3. (b) Social Security Number

*Don't know*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *December 14, 1946* at *5:40 PM*21. I CERTIFY that death occurred on the date above stated—that I attended deceased from *Medical Examiner Certificate* and that I last saw him *alive* on *19*.Immediate cause of death *Sunshot wound of abdomen*

DURATION

*sudden*

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op. *12/14/46*

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Homicide* Date of *12/14/46*Where did injury occur? *Salisbury Wicomico* (City or town) (County) (State)Injured at home, farm, industry, public place (where)? *Public place*Means of injury *Sunshot wound* Injured at work? *No*23. SIGNATURE *Oliver D. Fisher* M.D. or otherAddress *Salisbury and* Date signed *12/14/46*

RECEIVED

JAN 2 1947

BUREAU

2-35

Dr. Mayr

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 61

12505

CERTIFICATE OF DEATH

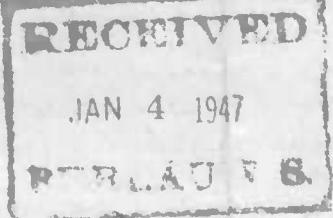
Reg. Dist. No. 9880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
County..... <u>W. Maryland</u>		(For newborn infants give residence of mother)	
City or town..... <u>S. Laurel</u> (If outside city or town limits, write RURAL and give nearest town)		State..... <u>Delaware</u> County..... <u>Sussex</u>	
How long in above place of death?		City or town..... <u>S. Laurel</u> R.F.D. (If outside city or town limits, write RURAL and give nearest town)	
Hospital, institution, or street address where death occurred: <u>Pensinsula General Hospital</u>		Street No.....	
How long in hospital or institution? <u>3 hrs.</u>		(If rural, give LOCATION)	
3. (a) FULL NAME		3. (b) Social Security Number	
<u>Boyce, Mr. Emory W.</u>			
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
<u>Male White</u>			
6. (b) Name of husband or wife..... <u>Samuel W. Boyce</u>		6. (c) If alive, give age..... <u>60</u> years	
7. Birth date of deceased (mo., day, yr.) <u>2 - 14 - 1887</u>		8. AGE: Years <u>59</u> Months <u>10</u> Days <u>5</u> If less than one day hrs. ..... min. ....	
9. Birthplace..... <u>Sussex Co Delaware</u> (Town, county, and state)		10. Usual occupation..... <u>Farmer</u>	
11. Industry or business		12. Name..... <u>Samuel Warren Boyce</u>	
13. Birthplace		14. Maiden name..... <u>Bartha Dunn</u>	
15. Birthplace		16. Informant..... <u>Elam D. Boyce</u>	
17. Burial, cremation, or removal. Which? <u>Burial</u>		Address..... <u>S. Laurel Del R.F.D.</u>	
Cemetery or crematory..... <u>J. D. T.</u>		Date thereof..... <u>12-21-46</u> (month) (day) (year)	
Location..... <u>S. Laurel</u>		18. Funeral director..... <u>Riggin &amp; Cooper</u>	
Address..... <u>S. Laurel Del</u>		19. Date rec'd by registrar..... <u>18/81</u> 19..... <u>1946</u> (Date rec'd by registrar)	

MEDICAL CERTIFICATION

20. DATE OF DEATH..... <u>December 19, 1946</u> , at <u>2:26 p.m.</u>	DURATION
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>12/19/46</u> to <u>12/19/46</u> , and that I last saw him <u>alive</u> on <u>12/19/46</u> .	
Immediate cause of death..... <u>Diabetic Coma</u>	
Due to..... <u>Diabetes mellitus</u>	
Due to.....	
Other conditions.....	
(Include pregnancy within 8 months of death)	
Major findings of operations.....	Date of op. ....
Autopsy results.....	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide..... Date of.....	
Where did injury occur? ..... (City or town) ..... (County) ..... (State)	
Injured at home, farm, industry, public place (where?) .....	
Means of Injury..... Injured at work?	
23. SIGNATURE..... <u>Charles M. Mayr</u> M. D. or other..... Address..... <u>S. Laurel Del</u> Date signed..... <u>12/20/46</u>	



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

Reg. Dist. No. 3330

12506

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

421, Marshall st.

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife

William J. Boyman

7. Birth date of deceased (mo., day, yr.)

March 15<sup>th</sup> 1872

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

.hrs. min.

9. Birthplace

Somerset Co. Morris Md.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

at home

12. Name

Gutman Heath

13. Birthplace

Morris Md.

14. Maiden name

Sarah Jane Loken

15. Birthplace

Somerset Co. Md.

16. Informant

M. Ottis Boyman

Address

421. Marshall st. Salisbury Md.

17. Burial

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Owles Cem.

Location

Owles Maryland

18. Funeral director

Holloway &amp; Co. Walter R. Holloway

Address

Salisbury Maryland

19. (Auto recd by registrar)

19. M.D. or other

(Name of physician)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 5<sup>th</sup> 1946 at 11:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1, 1946, to Dec. 5, 1946,

and that I last saw her alive on

Immediate cause of death

Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work

23. SIGNATURE

Johnson, Salter, D.D.S. M. D. or other

Address

Date signed 12-24-46

RECEIVED

DEC 24 1946

BUREAU

2-25

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-H

Box 12507

## CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH: *Nicomis*  
 County: *Salisbury*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, Institution, or street address where death occurred:  
*905 E. church st.*

How long in hospital or institution?

3. (a) FULL NAME

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife	7. Birth date of deceased (mo. day, yr.)	8. AGE: Years Months Days If less than one day	9. Birthplace (Town, county and state)
<i>Classe Brittingham</i>	<i>July 20 - 1919</i>	<i>27 40 18</i>	<i>Salisbury Maryland</i>

B. (c) If alive, give age	years
<i>726</i>	

10. Usual occupation	11. Industry or business
<i>Salisbury</i>	<i>Fred Brittingham</i>

12. Name	13. Birthplace
<i>Helen Billie</i>	<i>Sussex Co. Delaware</i>

14. Maiden name	15. Birthplace
<i>Helen Billie</i>	<i>Salisbury Maryland</i>

16. Informant	Address
<i>Mrs. Octavia Clegg Brittingham</i>	<i>112 East st. Delmar Del.</i>

17. Burial, cremation, or removal, Which	Date thereof (month) (day) (year)
<i>Burial</i>	<i>Dec. '11-1946</i>

Cemetery or crematory	Location
<i>M.E. Cemetery</i>	<i>Delmar Delaware</i>

18. Funeral director	Address
<i>Holloway &amp; Co. Walter P. Holloway</i>	<i>Salisbury Maryland</i>

19. Date record is registered	19. Hb.
<i>12/11/46</i>	

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: *Md.* County: *Nicomis*

City or town: *Salisbury* (If outside city or town limits, write RURAL and give nearest town)

Street No.: *905 E. Church st.* (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH *Dec. 8th 1946*

IDENTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw *him* alive on *Dec. 8th 1946*.Immediate cause of death *Sudden myocardial infarction*Due to *Sudden myocardial infarction*Due to *Sudden myocardial infarction*Other conditions *Sudden death*DURATION *Sudden death*

(Include pregnancy within 3 months of death)

Major findings of operations *None*Date of op. *no*Adopted, revised... *no*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Suicide* Date of *12/8/46*Where did injury occur? *Salisbury* (City or town) (County) (State) *Md.*Injured at home, farm, industry, public place (where)? *No*Means of Injury *Took gas on* Injured at work? *No**A Redemar*23. SIGNATURE *Deputy med. Examiner*M. D. or other *John E. Johnson*Address *Salisbury Md.* Date signed *12/10/46*

RECEIVED

JAN 2 1947

BUREAU OF INVESTIGATION

2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 102

12568

## CERTIFICATE OF DEATH

Reg. Dist. No. 3300

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

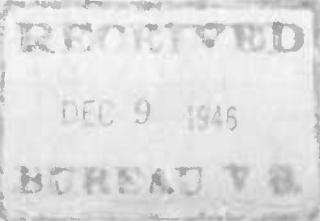
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:		St. Jamesicoe Mardela, Md.	
County.....		City or town.....	
(If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death?.....		all life	
Hospital, Institution, or street address where death occurred:			
How long in hospital or institution?			
3. (a) FULL NAME		6. Addie Bonaway	
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced Widowed	
F	N	6. (c) If alive, give age..... years 75	
6. (b) Name of husband or wife		Rev Wm Bonaway	
7. Birth date of deceased (mo., day, yr.)		July 13-1873	
8. AGE: Years		Months	Days
73		4	17
If less than one day		hrs.	min.
9. Birthplace.....		Mardela, St. Jamesicoe, Md.	
(Town, county, and state)			
10. Usual occupation		Housework	
11. Industry or business		James St Eversam	
MOTHER / FATHER	12. Name.....	James St Eversam	
	13. Birthplace	Md	
MOTHER	14. Maiden name	Eliza A Lloyd	
	15. Birthplace	Md	
16. Informant		Miss Edith J Eversam	
Address		Mardela, Md.	
17. Burial		Date thereof	12-5-1946
(Burial, cremation, or removal, which?)		(month)	(day)
Cemetery or crematory		Mardela, Md.	
Location		11	
18. Funeral director		Harrison Bros. Sharptown, Md.	
Address		W.H. Robertson	
19. 12/5/46		(Date rec'd by registrar)	Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:	
(For newborn infants give residence of mother)	
State.....	County.....
Md	St. Jamesicoe
City or town.....	
(If outside city or town limits, write RURAL and give nearest town)	
Street No.....	
(If rural, give LOCATION)	
2.(a) If veteran, name war.....	
3. (b) Social Security Number	

MEDICAL CERTIFICATION	
20. DATE OF DEATH	
12/2 1946 at 9:30 P.M.	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 1946, to December 2, 1946, and that I last saw her alive on December 2, 1946.	
Immediate cause of death	
Sobraw & mucous	
DURATION	
7 days	
Due to	
Due to	
Other conditions	
(Include pregnancy within 8 months of death)	
Major findings of operations	
Date of op.	
Autopsy results	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide..... Date of.....	
Where did injury occur?..... (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?)	
Means of injury	
Injured at work?	
23. SIGNATURE	
William Eversam	
M. D. or other	
Address	
Helton - Md. Date signed Dec 3-46	



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

## CERTIFICATE OF DEATH

12509  
Reg. Dist. No. 3370

**1. PLACE OF DEATH:**  
 County Wicomico  
 City or town White Haven Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Safe

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? nd

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)

State Md County Wicomico  
 City or town White Haven Md  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. nd  
 (If rural, give LOCATION)

2.(a) Is veteran, name war? no

**3. (a) FULL NAME** Ernest Francis Conway

4. Sex Male 5. Color or race A-A 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Arville Conway 7. Birth date of deceased (mo., day, yr.) yes 8. (c) Is alive, give age about 1874 years

7. Birth date of deceased (mo., day, yr.) about 1874

8. AGE: Years about 72 Months  Days  If less than one day  hrs.  min.

9. Birthplace White Haven Md  
 (Town, county, and state)

10. Usual occupation farmer

11. Industry or business Same as above

12. Name James Conway  
 MOTHER FATHER

13. Birthplace White Haven Md

14. Maiden name Mary Galls

15. Birthplace White Haven Md

16. Informant Mrs. Frances White

Address Salisbury Md

17. Burial Burial Date thereof Dec. 8-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Family

Location White Haven

18. Funeral director Ernest P. Stewart

Address Salisbury Md

19. (Date record by registrar) 1946 Registrar R. W. Ford Walter

**3. (b) Social Security Number** no

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1946, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that Lattened deceased from Arthritis on Oct. 6 1946 to Dec. 2 1946, and that I last saw him alive on Dec. 2 1946.

Immediate cause of death Artritis

Due to, Chronic Glomerulonephritis

Due to, Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  Date of op.

Autopsy results   
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  Date of

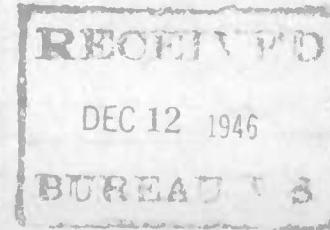
Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE E. Hennell M.D.  
 M. D. or other   
 Address 900 W. Main St. Salisbury signed 2/9/46

*County*  
COPY SENT TO LOCAL REGISTRAR No. ..... DATE 12-12-46



1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 301

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

12510 3930

Dr. Gilmore.

## 1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 7 hrs - 15 mins

Hospital, Institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 2 7 hrs - 15 mins

## 3. (a) FULL NAME

Daashields John Dashields

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

Col

widower

6.(b) Name of husband or wife

Annie Dashields

7. Birth date of deceased (mo., day, yr.)

do not know

6.(c) If alive, give age

87 years

8. AGE:

Years

Months

Days

If less than one day

About 54

-

hrs.

min.

8. Birthplace

Md

(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

Shoeing Dashields

12. Name

MOTHER FATHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date thereof

(month)

(day)

(year)

20. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

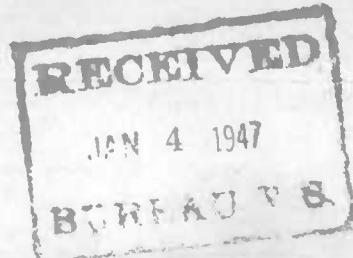
Date signed

Salisbury, Md.

Date

12/17/46

Year



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 11

## CERTIFICATE OF DEATH

Reg. Dist. No.

12511

3930

## 1. PLACE OF DEATH:

Wicomico

County

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 Years

Hospital, Institution, or street address where death occurred:

213 Snow Hill Road

How long in hospital or institution?

## 3. (a) FULL NAME

Clifford H. Duffy

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Thelma C. Duffy

7. Birth date of deceased (mo. day. yr.) Feb. 20, 1906. 6.(c) If alive, give age 38 years

8. AGE: Years Months Days If less than one day  
40 10 6 hrs. min.9. Birthplace Salisbury, Wicomico Co. Maryland.  
(Town, county, and state)

10. Usual occupation Cab. operator, Insurance

11. Industry or business Broker. General.

12. Name Ralph C. Duffy

13. Birthplace Salisbury, Md.

14. Maiden name Nancy J. Chatham

15. Birthplace Worcester, Co. Md.

16. Informant Mrs. Clifford H. Duffy

Address Salisbury, Md.

17. Burial Date thereof 12/29/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wicomico memorial Park

Location Salisbury, Md.

18. Funeral director The Hill &amp; Johnson Co.

Address Salisbury, Md.

19. (Date rec'd by registrar) 1947

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 213 Snow Hill Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1946 19 11 P.M. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Medical Examiner Report  
and that I last saw him alive on 17/26 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

sudden

Due to Acute Intracranial

2 weeks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Oscar G. Fisher, M.D. or other

Deputy medical Examiner, M.D. or other

Address 1000 S. Washington Rd. Date signed 17/26/46

RECEIVED

JAN 7 1947

FBI - BUREAU

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12512

## CERTIFICATE OF DEATH

Reg. Dist. No. 3.3.30

## 1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 7 days

## 3. (a) FULL NAME

Evans Mrs. Charles

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Single

## 6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of  
deceased (mo., day, yr.)Dec. 6, 1878

## 8. AGE:

Years

Months

Days

If less than one day

68 P 25 hrs. min.

## 9. Birthplace.....

Waterview, Wicomico, Md.  
(Town, county, and state)

## 10. Usual occupation.....

Costumeater

## 11. Industry or business

12. Name..... Robert G. Evans13. Birthplace Waterview, Md.14. Maiden name Sally Bradshaw15. Birthplace Waterview, Md.16. Informant J. Annah Collier SmithAddress Ohio Ave. Salisbury, Md.17. Burial..... Date thereof..... 1 3 '47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Turkey CemeteryLocation Manteo, Md.18. Funeral director C. G. MessickAddress Bivalve, Md.19. 1/22/47 19. 4/7/47 (Date rec'd by registrar) Katherine E. Johnson Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County WicomicoCity or town Waterview

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3119 46 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-31 19 46 to 12-31 19 46and that I last saw h. alive on 12-31-46

19

## Immediate cause of death.....

Cerebral HemorrhageDue to..... Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

Date of op.

Autopsy results..... Cerebral Hemorrhage, massive rt.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE..... William H. Fisher Jr. M.D.

M. D. or other

Address Peninsula Gen Hospital Date signed 1-1-47  
Salisbury, Md.

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1 - 35 -

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1330

12513

## CERTIFICATE OF DEATH

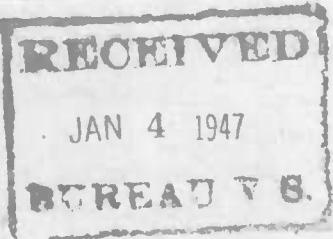
Reg. Dist. No. 1330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... Hospital, Institution, or street address where death occurred:..... How long in hospital or institution?.....	
3. (a) FULL NAME <b>FITCHETT, Juanita</b>	
4. Sex <b>Female</b>	5. Color or race <b>white</b>
6. (a) Single, married, widowed, or divorced <b>single</b>	
6. (b) Name of husband or wife..... <b>none</b>	
6. (c) If alive, give age..... years <b>October 17 1930</b>	
7. Birth date of deceased (mo., day, yr.)	
8. AGE: Years      Months      Days      If less than one day <b>16 2 7</b> hrs.      min.	
9. Birthplace..... (Town, county, and state) <b>Chincoteague va</b>	
10. Usual occupation..... <b>none</b>	
11. Industry or business	
MOTHER FATHER	12. Name..... <b>Judson Fitchett</b>
	13. Birthplace..... <b>Chincoteague va</b>
	14. Maiden name..... <b>Helene Birch</b>
	15. Birthplace..... <b>Chincoteague va</b>
16. Informant..... <b>Mrs. Helene Fitchett</b>	
Address..... <b>Chincoteague va</b>	Date thereof..... <b>Dec 27 1946</b>
17. (Burial, cremation, or removal, Which?) <b>Burial</b> Cemetery or crematory..... <b>Mechanics</b>	
Location..... <b>Chincoteague va</b>	
18. Funeral director..... <b>Walter M. Clark</b>	
Address..... <b>Chincoteague va</b>	Means of injury.....
19. Date rec'd by registrar..... <b>12/27/46</b>	Injured at work?

2. (a) If veteran, name war.....	2. (b) Social Security Number
3. MEDICAL CERTIFICATION	
20. DATE OF DEATH..... <b>24 December 46</b>	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <b>18 December 1946</b> to <b>24 December 1946</b> and that I last saw her <b>alive</b> on <b>24 December 1946</b> .	
Immediate cause of death..... <b>Acute pyelonephritis</b>	
Due to.....	
Due to.....	
Other conditions..... <b>Cerebral paralysis</b> from <b>Malnutrition</b> (Include pregnancy within 8 months of death) <b>3 weeks</b>	
Major findings or operations.....	
Autopsy results..... <b>none</b>	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide..... Date of.....	
Where did injury occur?..... (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?).....	
Means of injury..... Injured at work?	
23. SIGNATURE..... <b>Walter M. Clark</b>	
M. D. or other <b>MD</b>	
Address..... <b>221 1/2 Calden Ave.</b> Date signed..... <b>Salisbury MD</b> <b>25 Dec 46</b>	



2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-4

12514

## CERTIFICATE OF DEATH

Reg. Dist. No. 330

### 1. PLACE OF DEATH

County

City or town

Salisbury

17 years  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Hammond street

How long in hospital or institution?

### 3. (a) FULL NAME

Era Jane Greenblade

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

White married

B. (b) Name of husband or wife

George Alfred Greenblade

B. (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.)

March 9<sup>th</sup> 1882

8. AGE:

Years

Months

Days

If less than one day

64

11

11

hrs.

min.

9. Birthplace

Panama C.A.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

House wife

12. Name

Josephine Green

13. Birthplace

Panama

14. Maiden name

Josephine Green

15. Birthplace

France

16. Informant

M. Robert Greenblade

Address

Hammond st. Salisbury Md

17. Burial

Date thereof (month) (date) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Nilo. Mem. Park Cemetery

Location

Salisbury Maryland

18. Funeral director

Walter R. Holloman

Address

Salisbury Maryland

19. Date received by registrar

(Date rec'd by registrar)

12/24/46

Received by

John Johnson

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

City or town

Outside city or town limits, write RURAL and give nearest town

Street No.

Hammond street

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 20 1946 8 P.M.

I certify that death occurred on the date above stated; that I attended deceased from

1946 to Dec. 20, 1946

and that I last saw her alive on Dec. 20, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed

Signature

Address Date signed

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Robinson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

12515

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County

California  
Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Rensselaer General Hospital

4 hrs.

How long in hospital or institution?

4 hrs.

3. (a) FULL NAME

Hardy, James

4. Sex

Male

5. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Hardy

7. Birth date of deceased (mo. day yr.)

Nov. 9, 1922

8. AGE:

Years

24

Months

0

Days

22

If less than one day

hrs.

min.

9. Birthplace: (Town, county, and state)

Princess Anne, Somerset, Md.

10. Usual occupation:

Farm laborer

11. Industry or business

12. Name:

Carl Hardy

13. Birthplace:

Wilmington, Md.

14. Maiden name:

Lucilia Hardy

15. Birthplace:

Wilmington, Md.

16. Informant:

Mary Hardy

Address:

Salisbury, Md.

17. Burial (Burial, cremation, or removal, which?)

Burial

Cemetery or crematory:

John Wesley Cemetery

Location:

Princess Anne, Md.

18. Funeral director:

David F. Resnick

Address:

Salisbury, Md.

19. Date rec'd by registrar:

12/1/46

19. Date rec'd by registrar:

12/1/46

19. Date rec'd by registrar:

12/1/46

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State:

Md.

County:

Wicomico

City or town:

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

45

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH:

December 1st

1946

at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased

19

10

19

19

19

and that I last saw deceased alive on

Medical examination certificate

Immediate cause of death:

Fracture skull

Fractured mandible

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

none

Date of op.

Autopsy results:

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide:

accident

Date of:

12/1/46

Where did injury occur?

Salisbury

nearest Md.

(City or town)

Wicomico

(County)

State)

Injured at home, farm, industry, public place (where?)

Public street

Means of injury:

Two cars collided

Injured at work?

Yes

23. SIGNATURE:

Dr. Rademaker M.D.

Deputy medical Examiner

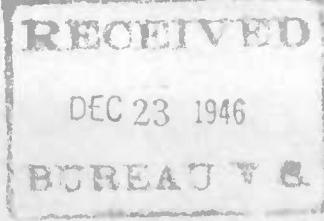
M. D. or other

Address:

Salisbury, Md.

Date signed:

12/1/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12516

## CERTIFICATE OF DEATH

Reg. Dist. No. 9990

## 1. PLACE OF DEATH:

Wicomico

County

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days - 19 hrs

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 3 days

## 3. (a) FULL NAME

Deanne Diana Jane

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 12-9-46

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

3 days hrs. min.

9. Birthplace: Salisbury, Wicomico, Md.

(Town, County, and state)

10. Usual occupation

## 11. Industry or business

12. Name: Norris Deanne

MOTHER FATHER: Welman Lee

14. Maiden name: Alma Parker

15. Birthplace: Millsboro

16. Informant: Norris Deanne

Address: Millsboro

17. Burial Date thereof: 12/13/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Carey's Cemetery

Location: Millsboro, Del.

18. Funeral director: Deaney Dickman

Address: Millsboro, Del.

19. Date rec'd by registrar: 12/13/46

(Date received by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Rural Millsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No:

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 1946 at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-9-46 to Dec. 12 1946

and that I last saw her alive on 12-12-46 1946

Immediate cause of death: Intracranial hemorrhage

Duration: 3 days

Due to: Birth injury

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: G.V. Wood

M. D. or other

Address: Date signed

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

12517

## CERTIFICATE OF DEATH

Reg. Dist. No. *3330*

## 1. PLACE OF DEATH: -

County.

*Maryland county*

City or town.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

*204 4th St.*

How long in hospital or institution?

## 3. (a) FULL NAME

*James Clarence Holden*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Col.

Married.

6. (b) Name of husband or wife.

*Alice Holden*

7. Birth date of deceased (mo., day, yr.)

*April 8th 1910*

6. (c) If alive, give age..... years

8. AGE:

Years  
*36.*Months  
*8*Days  
*23*

If less than one day

hrs.  
min.

9. Birthplace

*Onancock Va.*

(Town, county, and state)

10. Usual occupation

*Butler.*

11. Industry or business

*None*

12. Name

*Alton Holden*

13. Birthplace

*Onancock Va*

14. Maiden name

*Erne Custus*

15. Birthplace

*Onancock Va*

16. Informant

*Alice C. Holden*

Address

*204 4th St. Salisbury Md*

17. Burial

*Burial*Date thereof *Jan 5 1947*

(Burial, cremation, or removal. Which?)

Cemetery or crematory

*Onancock Va*

Location

*Onancock Cem.*

18. Funeral director

*Booker M. Clegg*

Address

*464 Lake St.*

19. (Date rec'd by registrar)

*1/9/47**Classical Socy Johnson*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

*3rd* County *Wicomico*

City or town

*Salisbury Md.*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

*204 4th Street.*

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Dec 31 1946 at 9:03 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*11-29 1946 to 12-31 1946*and that I last saw h. *alive* on *December 31 1946*

Immediate cause of death

*Cerebral Apoplexy*Due to *Hypertension*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *E.A. Lavelle, M.D.* M. D. or otherAddress *800 St. Main St. St. Mary's* Date signed *1-1-47*

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W. R. A. T. D.

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## STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County WicomicoVillage or City Salisbury, Maryland

Length of residence in city or town where death occurred.

yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

Registration Dist. No. 12518-35902. FULL NAME Lizzie Bailey Howard(a) Residence: No. Hebron, Maryland St.

Ward.

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED ( <i>write the word</i> ) <u>Widowed</u>
----------------------	-------------------------------	---

5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE <u>81</u>	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
		<u>4</u>	<u>27</u>	

July 27, 1865

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Housewife</u>	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.
10. Date deceased last worked at this occupation (month end year)	11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)  
(State or country) Wicomico County

13. NAME <u>Theodore Bailey</u>	14. BIRTHPLACE (city or town) <u>Wicomico County</u> (State or country) <u>Maryland</u>
15. MAIDEN NAME <u>Elizabeth Bennett</u>	16. BIRTHPLACE (city or town) <u>Wicomico County</u> (State or country) <u>Maryland</u>

17. INFORMANT Dalton B. Howard  
(Address)18. BURIAL, CREMATION, OR REMOVAL  
Place Hebron, Md. Date Dec. 27, 194619. UNDERTAKER M. Pugh Watson & Co.  
(Address) Salisbury, Md.20. FILED 12/27/46 12/27/46 J. Johnson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

December 24, 1946  
(Month) (Day) (Year)22. I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1946, to Dec. 24, 1946I last saw her alive on Dec. 24, 1946, death is said to have occurred on the date stated above, at 10:40 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary artery disease Date of onset  
1930

Other Contributory Causes of importance:

Arteriosclerosis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of Injury \_\_\_\_\_, 19\_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury \_\_\_\_\_

Nature of Injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) Robert F. Starr, M. D.  
(Address) 500 N. Division, Salisbury

**UNITED STATES STANDARD CERTIFICATE OF DEATH**

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.  
9.—The industry or business in which the work was done.  
10.—The month and year the deceased last worked at the occupation  
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc. as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

### Example 1

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>	<i>Attack of epilepsy</i>	<i>RECKIV</i>	<i>1 week ago</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>	<i>Ran over by street car</i>		<i>1 week ago</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>	<i>Peritonitis</i>	<i>JAN 4 19</i>	<i>3 days ago</i>
<b>Other contributory causes of importance:</b>		<b>Other contributory causes of importance:</b>		
<i>Gallstones</i>	<i>May 1, 1923</i>	<i>Gastroenteritis</i>		<i>1 year</i>

### Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	RECEIVED 1 week ago
Run over by street car	1 week ago
Peritonitis	JAN 4 1947 3 days ago
Other contributory causes of importance:	
Gastroenteritis	2-35 1 year

**ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Mann

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Pad*

12519

## CERTIFICATE OF DEATH

Reg. Dist. No. 293

## 1. PLACE OF DEATH

County

*Salisbury*

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*300 W. College Ave*

How long in hospital or institution?

## 3. (a) FULL NAME

*Louisa Emily Howard*

4. Sex

female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

*Scamille P. Howard*

7. Birth date of deceased (mo., day, yr.)

*Aug. 18 1865*6. (c) If alive, give age *dead* years

8. AGE:

Years      Months      Days      It less than one day  
81      3      25      hrs.      min.

9. Birthplace

*R.D. Mandeville Md.*  
(Town, county, and state)

10. Usual occupation

*At Home*

11. Industry or business

*William Jackson*

12. Name

*Oxford Co. Md.*

13. Birthplace

*Louisa Bradley*

14. Maiden name

*Dorchester Co. Md.*

15. Birthplace

*Mrs. Olive Banks*

16. Informant

*300 W. College Ave. Salisbury Md.*

Address

17. Buried

*Buried Dec. 15-1944*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date received by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2d. DATE OF DEATH

*Dec. 13 1946* at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dec. 12 1946* to *Dec. 13 1946*and that I last saw her alive on *Dec. 8 1946*

Immediate cause of death

*Coronary Thrombosis* DURATION *1 hr.*Due to *Valvular Heart Disease* DURATION *10 yrs.*Due to *Hypertension* DURATION *10 yrs.*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

*Frances R. Mann* M. D. or other *12/14/46*Address *Howard Salisby Md.* Date signed *12/14/46*

RECEIVED

JAN 2 1947

BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16

## CERTIFICATE OF DEATH

Reg. Dist. No. 1257333

## 1. PLACE OF DEATH:

County Wicomico Co  
 City or town Salisbury MD  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days  
 Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? 2 days

## 3. (a) FULL NAME

Leon S. Hudson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male A. A. married  
 6. (b) Name of husband or wife Elcie H. Hudson Don't know

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

years

July 5 1921  
 8. AGE: Years 25 Months 6 Days 6 If less than one day  
 hrs. ..... min. ....

9. Birthplace Salisbury (Town, county, and state)10. Usual occupation State Roads Commission11. Industry or business Same as above12. Name Oscar Hudson13. Birthplace Salisbury MD14. Maiden name Amy Parsons15. Birthplace Salisbury MD16. Informant Oscar HudsonAddress Salisbury MD17. Burial Burial Date thereof Oct 12-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HanlonLocation Salisbury MD18. Funeral director Jane H. StewartAddress Salisbury MD19. 12/15/46 19. H. L. Harriet E. Johnson Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico  
 City or town Salisbury MD  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. 164 (If rural, give LOCATION)

2.(a) If veteran, name war of World War 1942

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1946 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Decedent's Examiner Certificate 1946 1946  
 and that I last saw h. alive on 1946

Immediate cause of death

stab wound of heart sudden DURATIONDue to Homicide

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results stab wound of heart

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 12/11/46Where did injury occur? Salisbury Wicomico MD (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public placeMeans of Injury stab wound Injured at work? No23. SIGNATURE Class Sister, Inc. M. D. or otherAddress Salisbury MD Date signed 12/15/46

RECEIVED

JAN 2 1947

BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13<sup>th</sup>

## CERTIFICATE OF DEATH

Reg. Dist. No. 3333  
12520

## 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Hughes, Mr. Charles4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Mary Hughes7. Birth date of deceased (mo., day, yr.) November 8, 1876 8. (c) If alive, give age years8. AGE: Years 70 Months 1 Days 20 If less than one day hrs. min.9. Birthplace Seabrook, Wicomico, Md.  
(town, county, and state)10. Usual occupation Lumber11. Industry or business Steam Mill12. Name John Hughes13. Birthplace Seabrook, Md.14. Maiden name unknown15. Birthplace Seabrook, Md.16. Informant Mrs. Mary WrightAddress Shippstown, Md.17. Burial Date thereof (month) (day) (year)  
(Burial, cremation, or removal. Which?) Dec. 31, 1946Cemetery or crematory Seabrook, Md.Location Seabrook Cemetery18. Funeral director David K. MurphyAddress Seabrook, Maryland19. Date rec'd by registry 12/1/31, 1946. Signature of Registrar J. L. Johnson  
(Date rec'd by registry) (Signature of Registrar) (Date signed) 12/14/46

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WicomicoCity or town Seabrook (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH December, 28, 1946, at 9:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to Dec 28, 1946 and that I last saw him alive on Dec 28, 1946.

Immediate cause of death

Hypertension

Due to

Ch. Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Hypertension 12/24/46

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

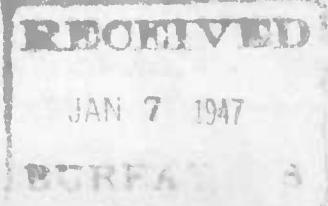
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. L. Johnson M. D. or other \_\_\_\_\_Address Seabrook, Maryland Date signed 12/14/46



2-35-

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

12521

## CERTIFICATE OF DEATH

Reg. Dist. No. 2330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County... Wicomico  
 City or town... Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial General HospitalHow long in hospital or institution? 3 1/2 hours

## 3. (a) FULL NAME

Jenkins, Mrs. Frank

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

WifeWhite

6. (b) Name of husband or wife

Alice M. Jenkins

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

1857

8. AGE:

Years  
95

Months

Days

If less than one day

.... hrs. .... min.

9. Birthplace

W.M.C.

(Town, county, and state)

10. Usual occupation

Waitress

11. Industry or business

Wm. Jenkins

12. Name

MOTHER FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof... Dec. 18, 1946

(month) (day) (year)

Cemetery or crematory

Parson Cemetery

Location

Salisbury, Md.

18. Funeral director

The Hill Johnson Co.

Address

Salisbury, Md.

19.

12/1/18 1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town, limits with RURAL and give nearest town)

Street No.

405 1/2 E. Vine St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

December 16, 1946 at 9:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 8, 1946 to Dec. 16, 1946and that I last saw him alive on Dec. 16, 1946.

Immediate cause of death

Cerebro-vascular accident

DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

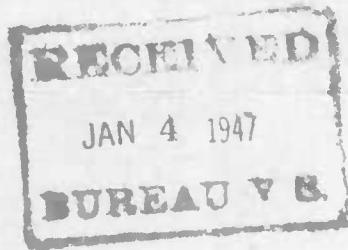
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles W. Leader M. D. or otherAddress Salisbury, Md. Date signed Dec. 16, 1946



2-35-

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

12522

## CERTIFICATE OF DEATH

Reg. Dist. No. 339

## 1. PLACE OF DEATH:

County..... Wicomico

City or town..... Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 11/26/46

Hospital, Institution, or street address where death occurred:

Eastern Shore Tb. Sanatorium

Salisbury, Md.

How long in hospital or institution? Since 11/26/46

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Wicomico

City or town..... Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 226 E. Locust St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## 3. (a) FULL NAME

Johnson, James, Market

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife..... Hannah E. Johnson

7. Birth date of deceased (mo., day, yr.) June 27, 1876

6.(c) If alive, give age..... 71 years

8. AGE: Years Months Days If less than one day

70 5 4 ..... hrs. ..... min.

9. Birthplace..... Wicomico County, Maryland  
(Town, county, and state)

10. Usual occupation..... Janitor

11. Industry or business

12. Name..... James J. Johnson

13. Birthplace..... Maryland Wicomico Co.

14. Maiden name..... Emma Parsons

15. Birthplace..... Maryland Wicomico Co.

16. Informant..... Mrs. Hannah E. Johnson

Address..... 226 E. Locust St. Salisbury

17. Burial Date thereof..... Oct. 3-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Wicomico Mem. Park

Location..... Salisbury Maryland

18. Funeral director..... Walter P. Halloway

Address..... Salisbury Maryland

19. (Date rec'd by registrar) 12/3/46

(Date reg'd by registrar) 12/3/46

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 1 1946 at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 26 1946 to Dec. 1 1946

and that I last saw h. i.m. alive on Dec. Nov. 30 1946

Immediate cause of death..... Pulmonary Tuberculosis

DURATION 2 month

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

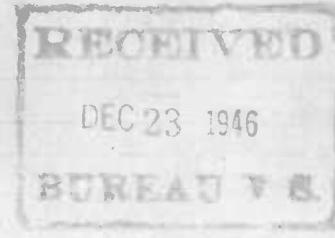
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Paul S. Rey M. D. or other.....

Address..... Show Hill, Md. Date signed..... 12/2/46



2-35-

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 64

## CERTIFICATE OF DEATH

Reg. Dist. No. 393

12523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital  
20 hours

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

C.

6.(b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

November 25, 1946

6.(c) If alive, give age

years

8. AGE:

Years Months Days If less than one day

10

hrs.

min.

9. Birthplace

(Town, county, and state) Westover, Maryland

10. Usual occupation

## 11. Industry or business

12. Name

MOTHER FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral Director

Address

19. (Date record is required)

Date record is required

19. Date record is required

Registrar

Signature

Date record is required

Signature

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Maryland County Somerset  
City or town Westover

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1978, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

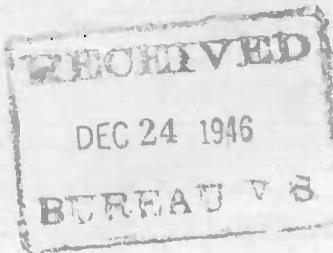
Immediate cause of death

Status Syphilitic

Due to Enlarged Thymus

Date of op. November

Autopsy result Collapsed Lung



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1542

## CERTIFICATE OF DEATH

12524

Reg. Dist. No.

## 1. PLACE OF DEATH

County Wilton

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Mason, Mrs Julia Anne

4. Sex

5. Color or race

Female white

(a) Single, married, widowed, or divorced

widow

## 6. (b) Name of husband or wife

John L. Mason

(c) If alive, give age years

June 29, 1874

7. Birth date of deceased (mo. day, yr.)

8. AGE: Years Months Days If less than one day  
72 5 19 hrs. min.

## 9. Birthplace

Maryland (Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Maryland City

## 12. Name

Maryland

## 13. Birthplace

Maryland

## 14. Maiden name

Harriet E. Richardson

## 15. Birthplace

Maryland

## 16. Informant

Mr. Ralph Mason

## Address

Newark Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)  
12/20/46

## Cemetery or crematory

M.E. Cemetery

## Location

Lewes Del. Md.

## 18. Funeral director

Doris A. Burdage

## Address

Berlin Md.

## 19. Date rec'd by registrar

12/30/46

19. H. S. Harriet E. Johnson

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Newark (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1946 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 1946 to Dec 18 1946

and that I last saw her alive on Dec 17 1946

Immediate cause of death Acute myocardial failure DURATION

Due to

Due to

Other conditions Death of her son

(Include pregnancy within 3 months of death)

Major findings or operations Abdomen Jan Date of op. Dec 19/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE J. M. Web M. D. or other

Address Salter Date signed Dec 19/46

RECEIVED

JAN 4 1947

BUREAU F.B.I.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Hop*

12525

## CERTIFICATE OF DEATH

Reg. Dist. No. *2930*

## 1. PLACE OF DEATH:

Wicomico  
Cedars.....

Salisbury Maryland

(If outside city or town limits, write RURAL and give nearest town)

Since 11/16/46

How long in above place of death?

Hospital, institution, or street address where death occurred:

Eastern Shore Tb. Sanatorium

How long in hospital or institution? Since 11/16/46

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Rt 2 Federalsburg Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. #2

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Nichols, Anna Elizabeth

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white married

6.(b) Name of husband or wife Paul Nichols

7. Birth date of deceased (mo. day, yr.) Sept. 28, 1907 6.(c) If alive, give age 40 years

8. AGE: Years Months Days If less than one day  
39 2 17 hrs. min.9. Birthplace Riverside, New Jersey  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Father Thomas Henry Stockley

13. Birthplace Denver, Colorado

14. Maiden name Mary Dockerty

15. Birthplace Maryland

16. Informant self

Address

17. Burial Date thereof 12-18-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Concord Cemetery

Location Concord, Md.

18. Funeral director Harry Williamson

Address Federalsburg, Md.

19. 12/18/46 Received by I. Johnson  
(Date rec'd by registrar) 1. Johnson  
Registrar

## 3. (b) Social Security Number

220-01-9648

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1946 at 9:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 16 1946 to Dec. 15 1946

and that I last saw her alive on Dec. 14, 1946

Immediate cause of death

Carcinoma of liver 1 mo.

Due to

Carcinoma with abdomen

Due to original lesion not located

Other conditions Rheumatic Carditis with Atrial fibrillation unknown

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul Shen M.D. M. D. or other

Address Snow Hill, Md. Date signed 12/16/46

RECEIVED

JAN 4 1947

BUREAU F.C.

2-35-

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

12526  
Reg. Dist. No. 25930

**M** The correct age  
**S** PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.  
**I** is especially important.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Sallie Sarena Giebold

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

## 6. (b) Name of husband or wife.....

J. W. J. Giebold

7. Birth date of deceased (mo. day, yr.)

Dec 24-1888

8. (c) If alive, give age..... years

## 8. AGE:

Years Months Days If less than one day  
58      ?      .      . hrs.      . min.

## 9. Birthplace.....

Wicomico County, Md.

(Town, county, and state)

## 10. Usual occupation.....

House work

## 11. Industry or business

Home

## 12. Name.....

Jas. B. Hutchins

## 13. Birthplace

Wicomico County, Md.

## 14. Maiden name.....

Mary Eller a/k/a

## 15. Birthplace

Wicomico County, Md.

## 16. Informant.....

J. W. J. Giebold

## Address

Delmar, Del.

## 17. Burial

Date thereof..... Jan 2-1947

(Burial, cremation, or removal, etc.)

(month) (day) (year)

## Cemetery or crematory

Giebold

## Location

Delmar, Md.

## 18. Funeral director.....

A. S. Giebold Co

## Address

Delmar, Del.

## 19. Date rec'd by registrar

1/2, 1947, Margaret E. Johnson, Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Wicomico

City or town..... Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No..... 2704 3 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 31 1946, at 12:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 31 1946, to Jan 31 1946

and that I last saw her alive on Dec 30 1946

Immediate cause of death..... Respiratory failure

Duration..... 3 days

Disease..... Respiratory failure

Duration..... 3 days

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. H. Lynch

M. D. or other

Address..... Belvoir Inn Date signed Dec 31 1946

RECEIVED

JAN 7 1947

B-TRAIL 18

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 140

## CERTIFICATE OF DEATH

12525  
Reg. Dist. No. 330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Wilomila  
 County Salsbury and

City or town Salsbury and  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 days

Hospital, institution, or street address where death occurred:  
Pennsauken General Hospital

How long in hospital or institution? 14 days

3. (a) FULL NAME

John W. Butter

4. Sex male 5. Color or race a a 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Mable R. Butter  
Don't know

7. Birth date of deceased (mo., day, yr.) Nov 27, 1864 6. (c) If alive, give age 82 years

8. AGE: Years 82 Months 0 Days 4 If less than one day hrs. . . . . min. . . . .

9. Birthplace Monticello and  
 (Town, county, and state)

10. Usual occupation Cysterman of Farmers

11. Industry or business Gabriel Butter

MOTHER FATHER 12. Name Gabriel Butter

13. Birthplace Monticello and

14. Maiden name Sarah Eby

15. Birthplace Monticello and

16. Informant Mrs. Mable Butter

Address Monticello and

17. Burial Burial Date thereof Dec 4-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Monticello

Location Monticello and

18. Funeral director James H. Stewart

Address Salsbury and

19. Date rec'd by registrar 12/4/46 19. 1946 20. Classified by 21. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State MD County Wilomila

City or town Monticello and  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 220 (If rural, give LOCATION)

2.(a) If veteran, name war no

3. (b) Social Security Number no

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1946 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 16, 1946, to Dec 1, 1946 and that I last saw him alive on Dec 1, 1946.

Immediate cause of death Coronary Occlusion

Due to arteriosclerosis (?)

Due to  

Other conditions  

(Include pregnancy within 3 months of death)

Major findings of operations  

Date of op.  

Autopsy results  

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide   Date of  

Where did injury occur?   (City or town)   (County)   (State)

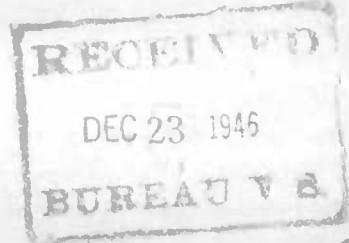
Injured at home, farm, industry, public place (where?)  

Means of injury   Injured at work?  

23. SIGNATURE John H. Yaman M. D. or other  

Address 232 Cameron Ave. Date signed  

Tolson, Md.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12528  
Reg. Dist. No. 3-30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Saboty*  
County: *Salisbury*

City or town: *Saboty* (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

*P.S. Hospital*

How long in hospital or institution?

3. (a) FULL NAME

*Ernest Frank Olijphant*

4. Sex: *Male* 5. Color or race: *White* 6.(a) Single, married, widowed, or divorced: *Married*

6.(b) Name of husband or wife: *Hettie Olijphant*

7. Birth date of deceased (mo., day, yr): *Oct. 29 - 1879* 6.(c) If alive, give age: *79* years

8. AGE: Years: *67* Months: *1* Days: *28* If less than one day: *hrs. 00 min. 00*

9. Birthplace: *Dorchester Co. Md.* (Town, county, and state)

10. Usual occupation: *Farmer*

11. Industry or business

12. Name: *Mutter Olijphant*

13. Birthplace: *Susex Co. Delaware*

14. Maiden name: *Mary Lant*

15. Birthplace: *R.D. 3, Delmar, Delaware*

16. Informant: *M. George Olijphant*

Address: *P.O. # 3. (Delmar Rd.) Salisbury*

17. Burial: *Burial* Date thereof: *Dec. 30-46* (Burial, cremation, or removal, which?)

Cemetery or crematory: *Acorn Cem.*

Location: *Saboty Maryland*

18. Funeral director: *Holloway & Waller Jr. Holloway*

Address: *Saboty Maryland*

19. (Date rec'd by registrar): *12/13/46* 19. (Date signed): *12/28/46*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: *Md.* County: *Wicomico*

City or town: *Saboty* (If outside city or town limits, write RURAL and give nearest town)

Street No.: *P.O. # 3.* (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *Dec. 27 1946* at *11:00 A.M.*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *December 26 1946* to *Dec. 27 1946* and that I last saw him alive on *Dec. 27 1946*.

Immediate cause of death:

*Tuber pneumonia*

Due to:

Due to:

Other conditions: *Deafness*

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE:

*A. V. Sohler, M.D.* D. or other  
Address: *Delmar, Md.* Date signed: *12-28-46*

RECEIVED

JAN 4 1947

BUREAU F.B.I.

1-35

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

## CERTIFICATE OF DEATH

12529  
Reg. Dist. No. 9330

## 1. PLACE OF DEATH:

County..... Wicomico  
City or town..... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 90 Years

Hospital, institution, or street address where death occurred:

..... 106 W. London Ave.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mary Ellen Parker

4. Sex ..... 5. Color or race ..... 6.(a) Single, married, widowed, or divorced

female white widowed

6.(b) Name of husband or wife..... George E. S. Parker

7. Birth date of deceased (mo., day, yr.) ..... Oct. 10, 1855

8. AGE: Years Months Days If less than one day  
91 I 21 hrs. min.9. Birthplace..... Wicomico Co. Maryland  
(Town, county, and state)

10. Usual occupation..... at Home

## 11. Industry or business

12. Name..... Thomas J. Calloway  
13. Birthplace..... Wicomico Co. Maryland.

14. Maiden name..... Amy P. Wilson

15. Birthplace..... Sussex Co. Del.

16. Informant..... Mrs. W. T. Chipman

Address..... Harrington. Del.

17. Burial..... Date thereof..... 12/ 3 / 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Parsons Cemetery

Location..... Salisbury. Md.

18. Funeral director..... The Hill &amp; Johnson Co.

Address..... Salisbury, Md.

19. (Date rec'd by registrar) ..... 12/13/46. (Signature) ..... Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Wicomico

City or town..... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 106 W. London Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 1, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on Nov. 30

Immediate cause of death.....

Septicemia

Due to..... Pyelitis

Due to.....

Other conditions..... Varicose Heart Disease 20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... Date of op.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

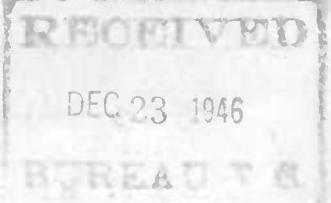
Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... (Signature) ..... M. D. or other.....

Address..... Salisbury, Md. Date signed 12/13/46



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Nock

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 408

CERTIFICATE OF DEATH

12530

Reg. Dist. No. 8330

1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

P.B. Hospital

How long in hospital or institution?

3. (a) FULL NAME

Lee Peterson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

B. (b) Name of husband or wife

Rosie May Peterson

7. Birth date of

deceased (mo., day, yr.)

Oct. 19 & 1891

6. (c) If alive, give age

41

years

8. AGE:

Years

Months

Days

If less than one day

55

1

23

hrs.

min.

9. Birthplace.....

Sweden

(Town, county, and state)

10. Usual occupation.....

Labor

11. Industry or business

Lumber Mill

12. Name

Jhm Peterson

13. Birthplace

Sweden

14. Maiden name

alma

15. Birthplace

Sweden

16. Informant

Mrs. Rosie M. Peterson

Address

P.O. Box 261. Delton Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Arlington Cemetery

Location

Arlington Maryland

18. Funeral director

Walter P. Hillman

Address

Arlington Maryland

19. (Date rec'd by registrar)

12/1/46

Reg. No.

12530

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

Sate.....

MD

County.....

Delton

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

P.O. Box 261.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 12<sup>th</sup> 46 at 4 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 15 1946 to Dec. 12 1946,

and that I last saw him alive on Dec. 12 1946.

Immediate cause of death

Carcinoma of Throat  
with metastasis to liver

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Sur

Date of op. Dec. 1, 1946

Autopsy results

Tumor

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

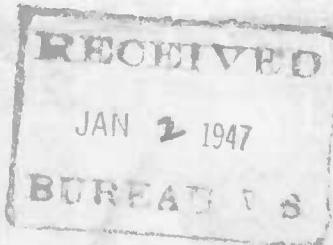
J. M. Webb

M. D. or other

Address

Delton

Date signed Dec. 14/1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12531

## CERTIFICATE OF DEATH

Reg. Dist. No. 3990

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County..... Wicomico

City or town..... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Peninsula General Hospital

How long in hospital or institution? I day

3. (a) FULL NAME

Addie Blanche Pollitt

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

female      white      single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1873

8. AGE: Years      Months      Days      If less than one day  
73      I      I      hrs.      min.

9. Birthplace..... Wicomico Co. Maryland.  
(Town, county, and state)

10. Usual occupation..... At Home

11. Industry or business

12. Name..... Levin Irving Pollitt

13. Birthplace..... Wicomico Co. Maryland.

14. Maiden name..... Ann Maria Ralph

15. Birthplace..... Sussex Co. Del.

16. Informant..... W. Ralph Pollitt

Address..... Salisbury, Maryland. R. D. 2

17. Burial..... Date thereof..... Dec. 9, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Parsons Cemetery

Location..... Salisbury, Maryland.

18. Funeral director..... The Hill & Johnson Co.

Address..... Salisbury, Maryland.

19. (Date record by registrar) 12/9/46

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland      County..... Wicomico

City or town..... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Rural 2

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 7, 1946 19 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 3 1946 to Dec 7 1946  
and that I last saw her alive on Dec 7 1946

Immediate cause of death.....

Coronary Thrombosis 4 days

Due to..... Arterio - Ocularis Nervous

Due to..... Value Heart Disease

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

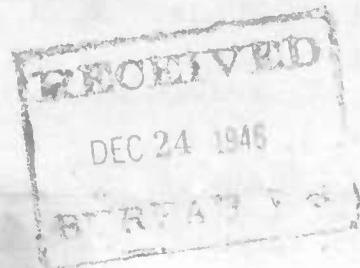
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE.....

M. D. or other \_\_\_\_\_  
Address..... John R. Mann  
Johnson & Johnson  
Salisbury, Maryland  
Date signed..... 12/8/46



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

12532

## CERTIFICATE OF DEATH

Reg. Dist. No. 3330

## 1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Powell, Master Orville

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white singles

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 2, 1932

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

14 9 24

hrs.

min.

9. Birthplace...  
(Town, county, and state)Pocomoke Worcester MD

10. Usual occupation

Schoolboy

11. Industry or business

MOTHER FATHER

Elton Powell

12. Name

Maryland

13. Birthplace

Ella Ella Turel

14. Maiden name

Maryland

15. Birthplace

Elton Powell

16. Informant

Rural Snow Hill Md.

Address

17. Burial

Date thereof. Dec 31-1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Salisbury City Cemetery

Location

Pocomoke MD

18. Funeral director

Henry Watson

Address

Pocomoke City MD

19. (Date rec'd by registrar)

12/31/46

19. (Date of birth)

Clarissa Johnson

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WorcesterCity or town... Rural Snow Hill MD

(If outside city or town limits, write RURAL and give nearest town)

Street No... 

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1946 at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 14 1946 to Dec 28 1946and that I last saw him... alive on Dec 28 1946

Immediate cause of death

Acute Appendicitis  
acute Cardiac Failure

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

HeartDate of op. 12/28/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other J. H. HallAddress Worcester Date signed 12/30/46

RECEIVED

JAN 7 1947

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2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27

12533

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

6 hours

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?.....

32 hrs 12 minutes

## 3. (a) FULL NAME

Marion Russell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female C.

## 6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

Dec. 16, 1946

8. AGE:

Years

Months

Days

If less than one day

min.

9. Birthplace.....

Berlin, Md

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

Russell Everett

13. Birthplace

Berlin, Md

14. Maiden name

Duffy Hazel

15. Birthplace

Salisbury, Md

16. Informant.....

Beatrice Duffy

Address

Sealins, Md

17. Burial

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Family Cemetery

Location

Snow Hill, Md

18. Funeral director

Beatrice Duffy

(acting)

Sealins, Md

19. Date record by registrar

12/17/46 Harriet L. Johnson

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Worcester

City or town.....

Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Rural #2

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

December 16, 1946, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18...

to

and that I last saw h.....alive on

19.

Immediate cause of death.....

DURATION

Prematurity

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

William H. Shadley

M. D. or other

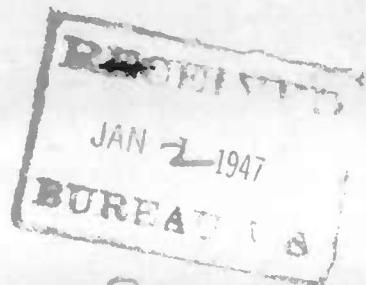
Address..... Date signed.....

12/17/46

Harriet L. Johnson

Registrar

12/17/46



2 - 85

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BC*

## CERTIFICATE OF DEATH

12534  
Reg. Dist. No. 3330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Homicide*  
 County: *Calvert*

City or town: *Salisbury* (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *8 days*

Hospital, institution, or street address where death occurred:

*Penitentiary General Hospital* *8 days*

How long in hospital or Institution?

3. (a) FULL NAME

*Edward Rowley*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Catherine Rowley*

7. Birth date of deceased (mo., day, yr.) *Aug. 27, 1889.* 6. (c) If alive, give age *55* years

8. AGE: Years *57* Months *3* Days *12* If less than one day

hrs. *0* min. *0*

9. Birthplace *Buxton, England*

(Town, County, and state)

10. Usual occupation *Commercial*

11. Industry or business *Millionaire*

12. Name *William Rowley*

13. Birthplace *England*

14. Maiden name *Eliza Louise Bennett*

15. Birthplace *India*

16. Informant *Mrs. Edward Rowley*

Address *Middle Springs, Md.*

17. Cremation Date thereof *11/10/46* (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Linden Park*

Location *13th Street, Md.*

18. Funeral director *The Hill Chapel Co.*

Address *Salisbury, Md.*

19. *10/9/46* (Date rec'd by registrar) 1946 (Date of death) *Carrie S. Johnson* (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State *Md.* County *Homicide*

City or town: *Middle Springs* (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (b) Social Security Number *✓*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 9, 1946, at 8:50 A.M.*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *Nov. 5, 1946*, to *Dec. 9, 1946*,

and that I last saw *him* alive on *1946*.

Immediate cause of death *Physical Stress*

DURATION

Due to *Physical Stress*

Due to *Physical Stress*

Due to *Physical Stress*

Other conditions *Physical Stress*

(Include pregnancy within 3 months of death)

Major findings or operations *Physical Stress*

Date of op. *Dec. 1, 1946*

Autopsy results *None*

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE *J. M. Lee* M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

DEC 24 1946

BUREAU F B I

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12535

## CERTIFICATE OF DEATH

Reg. Dist. No. 9330

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 weeksHospital, institution, or street address where death occurred: 105 Cheery Ln, SalisburyHow long in hospital or institution? 2 weeks

## 3. (a) FULL NAME

John W. Full4. Sex M5. Color or race W.6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife dead7. Birth date of deceased (mo., day, yr.) Jan. 15 - 18636. (c) If alive, give age 84 years8. AGE: Years 73 Months 11 Days 1If less than one day hrs. min.9. Birthplace Hanover, W. Va.

(Town, county, and state)

10. Usual occupation Farmer11. Industry or business William Full

MOTHER FATHER

12. Name William Full13. Birthplace Maryland14. Maiden name Elizabeth Hancock15. Birthplace Maryland16. Informant W. L. FullAddress 5827 Battleground Philadelphia Pa.17. Burial, cremation, or removal. Which? BurialDate thereof Dec 1946  
(month day year)Cemetery or crematory W. L. FullLocation Gwynedd City Md18. Funeral director Way E. DuganAddress Snow Hill, Md19. Date rec'd by registrar 12/19/4619. 46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury (If outside city or town limits, write RURAL and give nearest town)Street No. 105 Cheery Ln (If rural, give LOCATION) Salisbury2.(a) If veteran, name war None3. (b) Social Security Number None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 6th to Dec 16 and that I last saw him alive on Dec 16Immediate cause of death Shuttle of ParalysisDue to Decay of heartDue to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Cause of injury

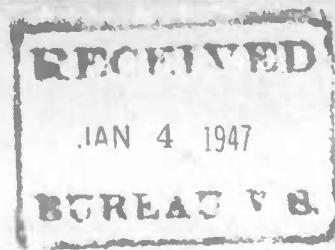
Injured at work?

23. SIGNATURE Carrie L. Hearn

M. D. or other

Address 2034 Church St Date signed Dec 1946

Salem, Maryland



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 33-30  
12536

1. PLACE OF DEATH: Hospital  
County Salisbury, Md.  
City or town Salisbury, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Twelve  
Hospital, Institution, or street address where death occurred: no  
How long in hospital or institution? no

3. (a) FULL NAME Armeda Harris Underwood4. Sex female 5. Color or race Aga. 6. Single, married, widowed, or divorced Married8. (b) Name of husband or wife James Underwood7. Birth date of deceased (mo., day, yr.) yes about 32 years8. AGE: Years 24 Months 0 Days 0 If less than one day hrs. 0 min. 09. Birthplace Bridgewater, Del.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Same as above12. Name Robert Harris13. Birthplace Boston, Mass.14. Maiden name Mercella Bonner15. Birthplace Bridgewater, Del.16. Informant Robert HarrisAddress Salisbury, Md.17. Burial Burial Date thereof Oct 17-1946  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory HoustonLocation Salisbury, Md.18. Funeral director James P. StewartAddress Salisbury, Md.19. 12/17/46 19. 46 (Date rec'd by registrar) Harriet L. Johnson Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn Infants give residence of mother)State md County Wicomico  
City or town Salisbury, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 300 Label Lake  
(If rural, give LOCATION) md.2.(a) If veteran, name war WWII3. (b) Social Security Number 217-12-4890

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17, 1946 at 10:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical 19 10 19 and that I last saw alive an anticipate 19 10 19.Immediate cause of death Pulmonary T.B. DURATION 6 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE J. Rademacher M.D. or otherAddress Salisbury, Md. Date signed Dec 17, 1946

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REF ID: A3

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

12537

## CERTIFICATE OF DEATH

Reg. Dist. No. 999

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Victor

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Cal. single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

Dec. 18. 1946

6. (c) If alive, give age years

## 8. AGE:

Years Months Days 11 less than one day  
0 0 7 hrs. min.

## 9. Birthplace

Salisbury Md Bar.  
(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

None

Robert Talland

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. Burial

(Burial, cremation, or removal, Which?)

(Cemetery or crematory)

Location

18. Funeral director

Address

19. Date record by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1946 at 7 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 18, 1946, to Dec 24, 1946

and that I last saw him alive on Dec 23, 1946

Immediate cause of death

Bronchitis - pneumonia

Due to Bronchitis - pneumonia

Due to Exposure to cold air

attending birth of 18/46

Other conditions (No prenatal care)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

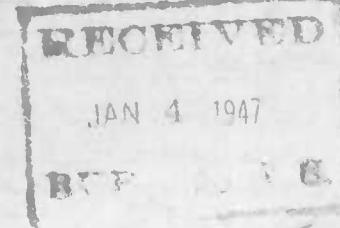
Means of Injury Injured at work

23. SIGNATURE G. Lembly, M.D.

M. D. or other

Address

Date signed 12/24/46



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

**2411 N. Charles St., Baltimore**

57

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

**UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WVS A15 04-07-01

1. PLACE OF DEATH		Bellevue		
County.....				
City or town.....		(If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death?				
Hospital, institution, or street address where death occurred:		606 N. Division street		
How long in hospital or institution?				
3. (a) FULL NAME		Emily Wanner		
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
Female	White	Married		
6. (b) Name of husband or wife		Jess R. Wanner		
6. (c) If alive, give age		58		
7. Birth date of deceased (mo., day, yr.)		Aug. 26 1905		
8. AGE:		Years	Months	Days
		41	3	21
		If less than one day ....hrs. ....min.		
9. Birthplace		Princess Anne Md.		
		(Town, county, and state)		
10. Usual occupation.		House wife		
11. Industry or business		at home		
12. Name		John E. Whetley		
13. Birthplace		Princess Anne Md.		
14. Maiden name		Anna Lamblon		
15. Birthplace		Princess Anne Md.		
16. Informant		Dr. Jess R. Wanner		
		506 N. Division St. Bellevue		
17. Burial		Date thereof	Dec. 19 1948	
		(month)	(day)	(year)
Cemetery or crematory		Bellevue Cemetery		
Locality		Maryland		
18. Funeral director		Walter R. H. Grayson & Co.		
Address		Bellevue Maryland		
19. (Date record by registrar)		13/19/48	19.	Charlie G. John
				Registr.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infant give residence of mother)

State..... County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 506 N. Division street  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

---

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 17<sup>th</sup> 1946 at 6:10a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19, 1946, to December 17, 1946  
 and that I last saw him alive on December 16, 1946.

Immediate cause of death..... Pulmonary edema.

Due to..... metastatic carcinoma lung.  
 Adm. Due to..... Carcinoma breast, left.

Other conditions.....

DURATION  
1-2 hrs  
6 months

(Include pregnancy within 3 months of death)

Major findings of operations..... adenocarcinoma breast, left. Date of op. May 1945

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.  
May

22. VIOLENCE: If death was due to external causes, fill in the following:

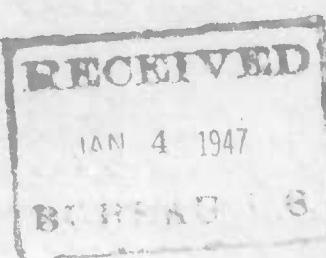
Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... William B. Long M.D.  
 M. D. or other  
 Address..... 504 N. Division St. Date signed 12/20/46



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9231

12539

## CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH: Salisbury

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

30 years

Hospital, institution, or street address where death occurred:

R.D.#1 or 1 Dr. St. Est.

How long in hospital or institution?

## 3. (a) FULL NAME

William Henry Wetzel4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced MarriedB.(b) Name of husband or wife Catherine Ann Wetzel7. Birth date of deceased (mo., day, yr.) Nov. 11<sup>th</sup> 18726.(a) If alive, give age 69 years8. AGE: Years 74 Months 0 Days 29 If less than one day  
hrs. . . . . min. . . . .9. Birthplace Washington, D.C.  
(Town, County, and state)10. Usual occupation House Painter

## 11. Industry or business

MOTHER FATHER Samuel Wetzel12. Name Samuel Wetzel13. Birthplace Washington, D.C.14. Maiden name Thompson15. Birthplace Washington, D.C.16. Informant Mrs. Catherine Ann WetzelAddress R.D.#1, Salisbury, Maryland17. Burial Date thereof Dec. 12-1946  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory W.C. Mem. ParkLocation Salisbury, Maryland18. Funeral director Holloway & Waller, R. HollowayAddress Salisbury, Maryland19. Date rec'd by registrar 12/1/4619. H. H. Hazelton, J. Johnson  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D.#1, S. Duham St. St.

Address.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10<sup>th</sup> 1946 at 6:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

30 Dec 1946 to Dec 9and that I last saw him alive on Dec 9Immediate cause of death Depression from infectedBladder due to Hypertrophy 2 mos.

Due to.....

Due to.....

Other conditions Hypertension whenValvular Heart Disease when

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

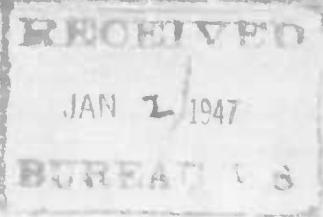
Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE James R. MurrayM. D. or other MD Date signed 12/1/46Address Salisbury, Md. Date signed 12/1/46



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

12540

## CERTIFICATE OF DEATH

Reg. Dist. No. 3330

## 1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

12 hours

How long in above place of death?

Hospital, institution, or street address where death occurred:

South Division St.

How long in hospital or institution?

## 3. (a) FULL NAME

John M. Whayland

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white widowed

6.(b) Name of husband or wife Mary L. Whayland

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1874.

8. AGE: Years Months Days If less than one day  
72 6 21 hrs. min.

9. Birthplace Allen, Wicomico Co., Maryland.

(Town, county, and state)

10. Usual occupation Retired Farmer

## 11. Industry or business

12. Name Thomas J. Whayland

13. Birthplace Wicomico Co. Maryland.

14. Maiden name Sarah P. Ackworth

15. Birthplace Wicomico Co. Maryland.

16. Informant William P. Whayland

Address Salisbury, Maryland. R. D. I

17. Burial Date thereof 12 7 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allen Cemetery

Location Allen, Maryland.

18. Funeral director The Hill &amp; Johnson Co.

Address Salisbury, Maryland.

19. (Date record by registrar) 1/3 1947 Harriet E. Johnson Social Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. D. I. Snow Hill Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec. 21, 1946 19 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Medical Examiner certified

and that I last saw h. alive on 19.

Immediate cause of death

Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... Harriet E. Johnson M. D. or other

Address Salisbury, Maryland Date signed 1/23/46

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1 - 35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

## CERTIFICATE OF DEATH

12541

Reg. Dist. No. 3270

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. SEX

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age in years

8. AGE:

Years      Months      Days      If less than one day  
81      8      28      .hrs.      .min.

9. Birthplace

(Town, county, and state).....

10. Usual occupation

Retired Farmer

11. Industry or business

Farmer

12. Name

James Willing

13. Birthplace

Biraltimore Md.

14. Maiden name

Susan Drury

15. Birthplace

Biraltimore Md.

16. Informant

Mrs Margaret E. Willing

Address

Biraltimore Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof.....  
(month) (day) (year)  
12/19/46

Cemetery or crematory

Brooklawn Cemetery

Location

Biraltimore Md.

18. Funeral director

C. Glenn Meisch

Address

Biraltimore Md.

19. Date rec'd by registrar

Dec. 22 1946 P. D. W. Miller

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... If outside city or town limits, write RURAL and give nearest town

Street No..... P.O. Box Biraltimore Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

Dec. 17th 1946 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1946 to December 15 1946 and that I last saw him alive on December 15 1946.

## Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to Atherosclerosis

?

Due to

Other conditions

?

(Include pregnancy within 8 months of death)

Major findings of operations

?

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?.....

23. SIGNATURE..... P. D. W. Miller M. D. or other

Address..... Montrose, Md. Date signed 12-22-46

